Wisconsin Medicaid Mental Health/ Substance Abuse Agency Certification Packet

Wisconsin
Department of
Health and Family Services

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Dear Medicaid Provider Applicant:

Thank you for applying for certification with the Wisconsin Medicaid program. Once you are a Medicaid provider, you will play a significant part in improving the health of low-income people in your community.

Enclosed are the certification materials you requested. Please review these materials carefully. These materials must be completed and processed before you may become a certified provider for the Wisconsin Medicaid program and begin receiving payments.

Upon certification as a Wisconsin Medicaid provider, you will receive the All Provider Handbook containing general instructions for all providers. In addition, you will also receive publications relating to the specific services you will be providing. These publications will identify the services covered by the Medicaid program and will describe Medicaid billing procedures. After reading those materials, if you have additional questions, we encourage you to use provider services. These services include both telephone and on-site assistance. If you are interested in using these services, please contact the Provider Services Unit addresses and telephone numbers listed in the All Provider Handbook.

We realize that all providers appreciate prompt payments, so we encourage providers with computers to submit claims electronically. This method reduces clerical errors and decreases turn around time. If you are interested in electronic submission of claims and would like more information, including the free software, please contact (608) 221-4746. Information is included in your certification materials regarding electronic submission of claims.

Thank you, again, for your interest in becoming a certified Wisconsin Medicaid provider and for the important services that you will provide to Medicaid recipients. If you have any questions about enclosed materials, please contact the Wisconsin Medicaid Correspondence Unit at (608) 221-9883 or toll-free at 1-800-947-9627.

Sincerely,

Peggy B. Handrich

Peggy B. Handrich
Associate Administrator

PBH:mhy
MA11065.KZ/PERM

Enclosure

Wisconsin Medicaid
Checklist for Certification

The items listed below are included in your certification application. Please use this form to check that you received the materials and verify which materials you returned. Please copy all documents for your records before sending them to the fiscal agent. Keep this checklist for your records. Mail your completed application to:

Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

The required items must be completed and returned to Wisconsin Medicaid:

	Item	Required	Optional	Date Sent
1.	Provider Application	X		
2.	Provider Agreement (2 copies)	X		

These items are included for your information. Do not return them:

	Item
1.	General Information
2.	Certification Requirements
3.	Terms of Reimbursement
4.	Electronic Billing Information

Wisconsin Medicaid Program
General Certification Information

Enclosed is the certification application you requested to be a Wisconsin Medicaid provider. Your certification for Wisconsin Medicaid can be approved when you send a **correctly completed application** to the address below and meet all certification requirements for your provider type. **Wisconsin Medicaid cannot reimburse any services you provide prior to your approved certification effective date.** Please carefully read the attached materials.

Where to Reach Us

If you have questions about the certification process, please call the Wisconsin Medicaid Correspondence Unit for Policy/Billing Information at (608) 221-9883 or toll-free at 1-800-947-9627.

Copy all application documents for your records. Send your completed certification materials to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Certification Effective Date

Wisconsin Medicaid regulations are followed when assigning your initial effective date as described here:

1. The date you notify Wisconsin Medicaid of your intent to provide services is the earliest effective date possible and will be your initial effective date **if**:
   - You meet all applicable licensure, certification, authorization, or other credential requirements as a prerequisite for Medicaid on the date of notification. Do not hold your application for pending licensure, Medicare, or other required certification. Wisconsin Medicaid will keep your original application on file. Send Wisconsin Medicaid proof of eligibility documents immediately once available for continued processing.
   - Wisconsin Medicaid receives your **properly completed certification** application within 30 days of the date the application was mailed to you.

2. If Wisconsin Medicaid receives your application more than 30 days after it was mailed to you, your initial effective date will be the date Wisconsin Medicaid receives your correctly completed application.

3. If Wisconsin Medicaid receives your incomplete or unclear application within the 30-day deadline, you will be granted one 30-day extension. Wisconsin Medicaid must receive your response to Wisconsin Medicaid's request for additional information within 30 days from the date on the letter requesting the missing information or item(s). This extension may allow you additional time to obtain proof of eligibility (such as license verifications, transcripts, other certification, etc.)

4. If you don't send complete information within the original 30-day deadline or 30-day extension, your initial effective date will be based on the date Wisconsin Medicaid receives your complete and accurate application materials.

Notification of Certification Decision

Within 60 days after Wisconsin Medicaid receives your completed application, you will be notified of the status of your certification. If Wisconsin Medicaid needs to verify your licensure or credentials, it may take longer. You will be notified as soon as Wisconsin Medicaid completes the verification process.

If you are certified to provide Medicaid services, you will receive written notice of your approval, including your Wisconsin Medicaid provider number and certification effective date.

Notification of Changes

Your certification in Wisconsin Medicaid is maintained only if your certification information on file at Wisconsin Medicaid is current. You must inform Wisconsin Medicaid in advance of any changes such as licensure, certification, group affiliation, corporate name, ownership, and physical or payee address. **Send your written notice to Wisconsin Medicaid Provider Maintenance** This notice must state when these changes take effect. Include your provider number(s) and signature. Do not write your notice or change on claims or prior authorization requests.

Failure to notify Wisconsin Medicaid of these types of changes may result in:

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.
- Suspension of payments in the event provider mail is returned to Wisconsin Medicaid for lack of current address.

Provider Agreement Form

Your agreement to provide Medicaid services must be signed by you and the Wisconsin Department of Health and Family Services. This agreement states that both parties agree to abide by Wisconsin Medicaid's rules and regulations.

The agreement is valid for a maximum of one year. All Provider Agreements expire annually on March 31. The Department of Health and Family Services may renew or extend the Provider Agreement at that time.

You cannot transfer, assign, or change the Provider Agreement.

The application includes two copies of the Provider Agreement. Complete, sign, and return both copies. Type or clearly print your name as the applicant's name both on the line on page 1 and on the appropriate line on the last page of the agreement. You must use the same provider name on the application forms and Provider Agreement. When the certification process is complete, you will receive one copy of your processed and signed Provider Agreement. The other copy will be kept in your Wisconsin Medicaid file.

Terms of Reimbursement (TOR)

The TOR explains current reimbursement methodologies applicable to your particular provider type. It is referenced by, and incorporated within, the provider agreement. Keep the TOR for your files.

Certification Requirements

The Wisconsin Administrative Code contains requirements that providers must meet in order to be certified for Wisconsin Medicaid. The code and any special certification materials applicable to your provider type are included as certification requirements.

Publications

Along with your notice, Wisconsin Medicaid will send one copy of all applicable provider publications. The publications include program policies, procedures, and resources you can contact if you have questions.

Many clinics and groups have requested to receive only a few copies of each publication, rather than a personal copy for each Medicaid-certified individual provider in the clinic or group. If you are an individual provider who is a member of a Medicaid-certified clinic or group, you may reassign your copy to your clinic or group office. Please decide if you wish to receive your personal copy of Medicaid publications or if it is sufficient for your Medicaid-certified clinic or group office to receive copies.

If you do not wish to receive personal copies of Medicaid publications, please complete the attached "Deletion from Publications Mailing List Form." If you wish to have your copy of publications reassigned to your clinic or group, also complete the "Additional Publications Request Form."

DIVISION OF HEALTH CARE FINANCING

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Jim Doyle
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State of Wisconsin

Department of Health and Family Services

Mental Health/Substance Abuse Services
Terms of Reimbursement

For mental health and/or substance abuse outpatient services (including services provided by Ph.D. psychologists, master's level therapists, AODA counselors, narcotic treatment service nurses), mental health day treatment for adults, substance abuse day treatment, and HealthCheck Other Services in the mental health and/or substance abuse areas:

- The Department will establish maximum allowable fees for all covered services provided to Medicaid recipients eligible on the date of service. The maximum allowable fees shall be based on various factors, including a review of usual and customary charges submitted to Medicaid, the Wisconsin Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

- For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum allowable fee established by the Department. Medicaid reimbursement, minus appropriate copayments and payments by other insurers, will be considered to be payment in full.

For crisis intervention services, community support program services, comprehensive community services, and mental health and/or substance abuse outpatient services in the home or community:

- The Department will establish contracted rates for all covered services provided to Medicaid recipients eligible on the date of service. The contracted rates are applicable to all service components provided for certified agencies by providers under contract to that agency. The contracted rates shall be based on various factors, including provider costs submitted to Wisconsin Medicaid, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Contracted rates may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

- Providers will be reimbursed by Wisconsin Medicaid only for that portion of allowable costs for which federal financial participation is available. The State share will come from non-federal funds or federal funds authorized for use as match to other federal funds available to the agency. The agency will be responsible for maintaining an audit trail to document their contribution of this State share.

For services covered in this reimbursement:

- Providers are required to bill their usual and customary charges for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to non-Medicaid patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

- The Department will adjust payments made to providers to reflect the amounts of any allowable copayments which the providers are required to collect pursuant to Chapter 49, Wisconsin Statutes.

- Payments for deductible and coinsurance payable on an assigned Medicare claim shall be made in accordance with Section 49.46(2)(c), Wisconsin Statutes.

- In accordance with federal regulations contained in 42 CFR 447.205, the Department will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting rates for services.

Applicable Provider Types: 19, 20, 21, 22/Specialty 026
31, 55, 60, 67, 74, 89

WISCONSIN MEDICAID

PROVIDER APPLICATION
MENTAL HEALTH / SUBSTANCE ABUSE AGENCY SERVICES
INFORMATION AND INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

INSTRUCTIONS: Type or print your information on this application. Complete all sections. If a question does not apply to your application, write "N/A" in the field. Failure to complete all sections of this application will cause delay and may cause denial of certification.

IMPORTANT NOTICE: In receiving this application from and granting Medicaid certification to the individual or other entity named below as "Provider Applicant," Wisconsin Medicaid relies on the truth of all the following statements:

1. Provider Applicant submitted this application or authorized or otherwise caused it to be submitted.

2. All information entered on this application is accurate and complete, and that if any of that information changes after this application is submitted Provider Applicant will timely notify Wisconsin Medicaid of any such change.

3. By submitting this application or causing or authorizing it to be submitted, Provider Applicant agrees to abide by all statutes, rules, and policies governing Wisconsin Medicaid.

4. Provider Applicant knows and understands the certification requirements included in the application materials for the applicable provider types.

If any of the foregoing statements are not true, Wisconsin Medicaid may terminate Provider Applicant's certification or take other action authorized under ch. HFS106, Wis. Admin. Code, or other legal authority governing Wisconsin Medicaid.

With this application, you may be certified for one or more of the following mental health or substance abuse (alcohol and other drug abuse) services:

- Mental health outpatient services.
- Substance abuse outpatient services.
- Narcotic treatment services.
- Mental health day treatment for adults.
- Substance abuse day treatment.
- Child/adolescent day treatment (HealthCheck “Other Services”).
- Crisis intervention services.
- Community support program.
- Mental Health and/or substance abuse outpatient services in the home or community.
- Comprehensive community services.

FOR OFFICE USE ONLY

ECN	Date Requested	Date Mailed
Wisconsin Medicaid Provider Number	Effective Date	
Provider Type	Provider Specialty	

WISCONSIN MEDICAID

PROVIDER APPLICATION
MENTAL HEALTH / SUBSTANCE ABUSE AGENCY SERVICES

INSTRUCTIONS: Type or print clearly. Before completing this application, read Information and Instructions.

IMPORTANT: In order to complete only one application, the applicant's name and address in Sections I and II must be exactly the same for all the mental health and/or substance abuse (alcohol and other drug abuse) services for which the applicant wishes to receive Medicaid certification. If the applicant uses a different provider name for different services, the applicant must complete an application for each service under each different provider name.

For each service for which the applicant wishes to receive Medicaid certification, the applicant must attach the requested documents as listed in Section III. We will not be able to process the certification for that service if the applicant does not attach the documents; the applicant will then need to complete another entire certification application.

This application is being completed to (check one):
☐ Request Medicaid certification for an agency.
☐ Notify Wisconsin Medicaid of a change in ownership of a currently certified group/clinic.

Current Medicaid Provider Number	Effective Date of Change in Ownership

SECTION I — PROVIDER NAME AND PHYSICAL ADDRESS

Special Instructions
Name — Group / Agency — Enter only one name. All applicants must enter their name on this line. If your agency uses a "doing business as" (DBA), then enter your DBA name. The name entered on this line must exactly match the provider name used on all other documents for Wisconsin Medicaid.

Attention to — Use this line as an attention line to ensure proper mail delivery.

Address — Physical Work — Indicate address where services are primarily provided. This is the address used for mailing Medicaid information. It is not acceptable to use a drop box or post office box alone. Do not use a Medicaid recipient's residence or a billing service address. Official correspondence will be sent certified. Failure to sign for official correspondence could result in decertification. It is not acceptable to use a drop box or post office box alone. Do not use a Medicaid recipient's residence or a billing service address.

Name — Medicaid Contact Person and Telephone Number — List the name, title, and telephone number of a person within your organization who can be contacted about Medicaid questions. Also list a telephone number clients can use to reach you. This telephone number must be kept current with Wisconsin Medicaid.

Medicare Part A Number, Medicare Part B Number, and Effective Dates — Required for Medicare-certified providers. Use Medicare numbers appropriate for the same type of services as this application.

Name — Group / Agency		Attention to	
Address — Physical Work			
City	State	Zip Code	County
Name — Medicaid Contact Person	Title	Telephone Number	Fax Number
Medicare Part A Number			Effective Date
Medicare Part B Number			Effective Date

SECTION II — PROVIDER PAYEE NAME AND PAYEE ADDRESS

Special Instructions
Name — Payee — Enter the name to whom checks are payable. Individuals reporting income to the Internal Revenue Service (IRS) under a SSN must enter the individual name recorded with the IRS for the SSN. Applicants reporting income to the IRS under an employer identification number (EIN) must enter the name exactly as it is recorded with the IRS for the EIN.

TIN — Enter the Taxpayer Identification Number (TIN) that should be used to report income to the IRS. Check whether the TIN is an EIN or SSN. The number entered must be the TIN of the payee name entered. The payee name and TIN must exactly match what is on record with the IRS.

TIN Effective Date — This is the date the TIN became effective for the provider.

Attention to (Optional) — Enter an additional name that should be printed on checks and Remittance and Status (R/S) Reports (payment/denial report) to ensure proper delivery.

Address — Payee — Indicate where checks and R/S Reports should be mailed. A post office box alone may be used for this address.

Name — Payee		
TIN	TIN Effective Date	☐ EIN or ☐ SSN
Attention to		
Address — Payee		
City	State	Zip Code

SECTION III — CERTIFICATION CRITERIA

Special Instructions
Check the box next to each service for which the applicant wishes to be certified with Wisconsin Medicaid. Also, for each service that the applicant checked, check the appropriate boxes that apply and **attach all applicable documentation**. Keep a copy for future reference. This section covers Medicaid certification requirements for all Medicaid mental health substance abuse services.

If there are any questions or concerns regarding certificates issued by Division of Supportive Living, Wisconsin Department of Health and Family Services (DHFS), contact M. Bid Webb at (608) 243-2025.

☐ **Mental Health Outpatient Services**
Check option 1 (one box only) or option 2.

1. **Attach** a copy of the agency's Wisconsin DHFS certificate to provide mental health outpatient services, as authorized under HFS 61.91-61.98, Wis. Admin. Code.

   The agency is (check only one):

   ☐ A county-owned outpatient mental health clinic.

   This clinic is assigned a billing performing provider number. The clinic number is required on all claims. Individual staff must meet applicable requirements listed under psychiatrist services, Ph.D. psychologists, or master's level therapist services, but they are not required to be individually certified with Wisconsin Medicaid.

   ☐ A hospital outpatient mental health clinic, which is located at the hospital site.

   This clinic uses its assigned outpatient hospital number, which is required on all claims. Individual staff must meet applicable requirements listed under psychiatrist services, Ph.D. psychologist services, or master's level therapist services, but they are not required to be individually certified with Wisconsin Medicaid.

   ☐ Other outpatient mental health clinic (including a clinic that is owned and operated by a hospital, but not located within the hospital site).

   This clinic is assigned a billing number. Individual staff (Ph.D. psychologist or master's level therapists) are required to be individually certified with Wisconsin Medicaid. Ph.D. psychologists are assigned billing performing provider numbers; master's level therapists are assigned nonbilling performing provider numbers. For master's level therapist services, both the clinic's billing number and the individual nonbilling performing number must be on the claim.

2. ☐ Select this box only if you are a county or tribal agency and do not have a DHFS certificate to provide mental health outpatient services, as authorized under HFS 61.91-61.98, Wis. Admin. Code. Select this box only if you wish to be issued a billing provider number. The agency must use the contracted provider's individual performing provider number in the performing provider field on all claim forms. Both numbers are required on all claims.

☐ **Substance Abuse Outpatient Services**
Check option 1 (one box only) or option 2.

1. **Attach** a copy of the agency's DHFS certificate to provide substance abuse outpatient services, as authorized under HFS 75.13 or 75.15, Wis. Admin. Code.

   The agency is (check only one):

   ☐ A county-owned outpatient substance abuse clinic.

   This clinic is assigned a billing performing provider number. The clinic number is required on all claims. Individual staff must meet applicable requirements listed under psychiatrist services, Ph.D. psychologists, master's level therapist services, or AODA counselor services, but they are not required to be individually certified with Wisconsin Medicaid.

   ☐ A hospital outpatient substance abuse clinic, which is located at the hospital site.

   This clinic uses its assigned outpatient hospital number, which is required on all claims. Individual staff must meet applicable requirements listed under psychiatrist services, Ph.D. psychologist services, master's level therapist services, or AODA counselor services, but they are not required to be individually certified with Wisconsin Medicaid.

SECTION III — CERTIFICATION CRITERIA — Substance Abuse Outpatient Services (continued)

☐ Other outpatient substance abuse clinic (including a clinic that is owned and operated by a hospital, but not located within the hospital site).

This clinic is assigned a billing number. Individual staff (Ph.D. psychologist, master's level therapists, or AODA counselors) are required to be individually certified with Wisconsin Medicaid. Ph.D. psychologists are assigned billing performing provider numbers; master's level therapists are assigned nonbilling performing provider numbers. For master's level therapist services, both the clinic's billing number and the individual nonbilling performing number must be on the claim.

2. ☐ Indicate here if this clinic is an approved Narcotic Treatment Service according to HFS75.15. ☐ Yes ☐ No

3. ☐ Select this box only if you are a county or tribal agency and do not have a DHFS certificate to provide substance abuse outpatient services, as authorized under HFS 75.13 or 75.15, Wis. Admin. Code. Select this box only if you wish to be issued a billing provider number. The agency must use the contracted provider's individual performing provider number in the performing provider field on all claim forms. Both numbers are required on all claims.

☐ **Mental Health Day Treatment for Adults**
Check option 1 or option 2.

1. ☐ **Attach** a copy of the agency's DHFS certificate to provide mental health day treatment services, as authorized under HFS 61.75, Wis. Admin. Code (as required by HFS 105.24, Wis. Admin. Code).
2. ☐ Select this box only if you are a county tribal agency and do not have a DHFS certificate to provide mental health day treatment services, as authorized under HFS 61.75, Wis. Admin. Code (as required under HFS 105.24, Wis. Admin. Code). Select this box only if you wish to be issued a billing provider number. The agency must use the contracted provider's billing number (the agency's mental health day treatment billing number) in the performing provider field on all claim forms. Both numbers are required on all claims.

☐ **Substance Abuse Day Treatment**
Check option 1 or option 2.

1. ☐ **Attach** a copy of the agency's DHFS certificate to provide substance abuse day treatment services, as authorized under HFS 75.12, Wis. Admin. Code (as required by HFS 150.25, Wis. Admin. Code).
2. ☐ Select this box only if you are a county or tribal agency and do not have a DHFS certificate to provide substance abuse day treatment services, as authorized under HFS 75.12, Wis. Admin. Code (as required by HFS 150.25, Wis. Admin. Code). Select this box only if you wish to be issued a billing provider number. The agency must use the contracted provider's billing number (the agency's substance abuse day treatment billing number) in the performing provider field on all claim forms. Both numbers are required on all claims.

☐ **Child / Adolescent Day Treatment (HealthCheck "Other Services")**
Check option 1 or option 2.

1. ☐ **Attach** a copy of the agency's DHFS certificate to provide child/adolescent day treatment, as authorized under HFS 40, Wis. Admin. Code.
2. ☐ Select this box only if you are a county or tribal agency and do not have a DHFS certificate to provide child/adolescent day treatment (HealthCheck "Other Services"), as authorized under HFS 40, Wis. Admin. Code. Select this box only if you wish to be issued a billing provider number. The agency must use the contracted provider's billing number (the agency's child/adolescent day treatment billing number) in the performing provider field on all claim forms. Both numbers are required on all claims.

☐ **Crisis Intervention Services**
The matching funds agency, which will provide the state share, nonfederal funds, will be issued a billing-only provider number. The performing provider will be issued a non-billing provider number. Both numbers are required on all claims. Wisconsin Medicaid pays only the matching funds agency for crisis intervention services.

Check all boxes that apply:

☐ I verify that the agency is the "matching funds agency." I understand that the agency will receive a billing-only provider number by checking this box. I verify that the agency is one of the following (check one):
- ☐ County 51.42 Board (Community Programs).
- ☐ County Human Services Department.
- ☐ County 51.42/.437 Unified Board.
- ☐ County Social Service Department.
- ☐ County Aging Unit.
- ☐ Multi-county agency.
- ☐ Tribal government agency.

☐ **Attach** a copy of the agency's DHFS certificate to provide crisis intervention services, as authorized under HFS 34, Wis. Admin. Code. The provider that actually provides the services is issued a nonbilling performing provider number. Wisconsin Medicaid reimburses only the matching funds agency for crisis intervention services.

☐ **Community Support Program**
The matching funds agency, which will provide the states share, nonfederal funds, will be issued a billing-only provider number. The performing number will be issued a nonbilling performing provider number. Both numbers are required on all claims. Wisconsin Medicaid pays only the matching funds agency for community support program.

Check all that apply:

☐ I verify that the agency is the "matching funds agency." I understand that the agency will receive a billing-only provider number by checking this box. I verify that the agency is one of the following (check one):
- ☐ County 51.42 Board (Community Programs).
- ☐ County Human Services Department.
- ☐ County 51.42/.437 Unified Board.
- ☐ County Social Service Department.
- ☐ County Aging Unit.
- ☐ Multi-county agency.
- ☐ Tribal government agency.

☐ **Attach** a copy of the agency's DHFS certificate to provide community support program, as authorized under HFS 63, Wis. Admin. Code. The provider that actually provides the services is issued a nonbilling performing provider number. Wisconsin Medicaid reimburses only the matching funds for community support program.

☐ **Mental Health and / or Substance Abuse Outpatient Services in the Home or Community**
The matching funds agency, which will provide the state share, nonfederal funds, will be issued a billing-only provider number. When the matching funds agency has only a billing-only provider number, it must use the contracted provider's billing number (the agency's mental health and/or substance abuse billing number) in the performing provider field on all claim forms. Both numbers are required on all claims. Wisconsin Medicaid pays only the matching funds agency for mental health and/or substance abuse outpatient services in the home of community.

☐ I verify that the agency is the "matching funds agency." Attached is the agency resolution stating that the county or tribe agrees to make available the non-federal share needed to provide Medicaid mental health and substance abuse outpatient services in a home or community setting. I verify that the agency is one of the following (check one):
- ☐ County 51.42 Board (Community Programs).
- ☐ County Human Services Department.
- ☐ County 51.42/.437 Unified Board.
- ☐ County Social Service Department.
- ☐ County Aging Unit.
- ☐ Multi-county agency.
- ☐ Tribal government agency.

Check one of the following:

☐ The agency is also certified as a mental health/substance abuse clinic. Thus, I understand that our agency will use its mental health/substance abuse clinic provider number to bill these agencies. I verify that the agency is the "matching funds agency."

☐ I request that the agency receive a billing provider number since our agency is not certified as a mental health/substance abuse clinic. I understand that the agency will receive a billing-only provider number by checking this box.

☐ **Comprehensive Community Services**
The matching funds agency, which will provide the state share, non-federal funds, will be issued a billing-only provider number. The performing provider will be issued a non-billing performing provider number. Both numbers are required on all claims. Wisconsin Medicaid pays only the matching funds agency for comprehensive community services.

Check all that apply:

☐ I request that the agency receive a billing provider number. I verify that the agency is the "matching funds agency." I understand that the agency will receive a billing provider number by checking this box. Attached is the agency resolution stating that the county or tribe agrees to make available the non-federal share needed to provide Medicaid comprehensive community services. I verify that the agency is one of the following (check one):
- ☐ County 51.42 Board (Community Programs)
- ☐ County Human Services Department
- ☐ County 51.42/.437 Unified Board
- ☐ County Social Service Department
- ☐ County Aging Unit
- ☐ Multi-county agency
- ☐ Tribal government agency

☐ **Attached** is a copy of the agency's DHFS certificate to provide comprehensive community services, as authorized under HFS 36, Wis. Admin. Code. The provider that actually provides the services is issued a non-billing performing provider number. Wisconsin Medicaid reimburses only the matching funds agency for comprehensive community services.

SECTION IV — APPLICANT'S TYPES OF SERVICE PROVIDED AND TYPE OF BUSINESS

1. List the types of Medicaid services the applicant's agency will provide (such as dental, emergency transportation, home health, personal care, pharmacy, physician, psychiatric counseling, respiratory care services, etc.).

2. Applicant's type of business (check appropriate box):

☐ Individual.

☐ Sole Proprietor:
County and state where registered _____.

☐ Corporation for Nonprofit.

☐ Limited Liability.

☐ Corporation for Profit.
State of registration _____

Names of corporate officers _____

_____

☐ Partnership.
State of registration _____.

Names of all partners and SSNs (use additional sheet if needed):

Name _____ SSN _____

Name _____ SSN _____

Governmental (check one):

☐ County.

☐ State.

☐ Municipality (city, town, village).

☐ Tribal.

☐ Other, specify _____.

Definitions for Sections V-VII

Controlling Interest — Controlling interest includes, but is not limited to, those enumerated; that is, all owners, creditors, controlling officers, administrators, mortgage holders, employees or stockholders with holdings of 10% or greater of outstanding stock, or holders of any other such position or relationship who may have a bearing on the operation or administration of a medical services-related business.

SECTION V — TERMINATION / CONVICTION / SANCTION INFORMATION

During the preceding five years, has the applicant, any employee f the applicant, any person in whom the applicant has a controlling interest, or any person having a controlling interest in the applicant been terminated from or convicted of a crime related to a federal or state program?

☐ **Yes** ☐ **No**

If yes, explain:

SECTION VI — CONTROLLING INTEREST IN OTHER HEALTH CARE PROVIDERS

Copy this page and complete as needed.

Does the applicant have a controlling interest in any vendors of special service categories such as, but not limited to, drugs/pharmacy, medical supplies/durable medical equipment, transportation, visiting nurse and/or home health agency, or providers of any type of therapy.

☐ **Yes.** Identify each health care provider the applicant has a controlling interest or ownership in, supply the information, and describe the type and percentage of controlling interest or ownership (e.g., 5% owner, 50% partner, administrator).
☐ **No.** Go to Section VII.

Name			
Medical Provider Number(s)	SSN / EIN		
Address			
City	State	Zip Code	County

Telephone Number — Business	Telephone Number — Home	Type and percentage of controlling interest or ownership

Are all of the services provided by the applicant and any special service vendors in which the applicant has a controlling interest billed under a single provider number?

☐ **Yes.** Enter the number:_____.
☐ **No.**

SECTION VII — CONTROLLING INTEREST OTHERS (INDIVIDUAL AND / OR ENTITY) HAVE IN THE APPLICANT

Copy this page and complete as needed.

Does any person and/or entity have a controlling interest in any of the Medicaid services the applicant provides? ☐ **Yes** ☐ **No**

If yes, list the names and addresses of all persons and/or entities with a controlling interest in the applicant.

Name — Person or Entity			
Address			
City	State	Zip Code	County
Telephone Number — Business	Telephone Number — Home	Type and percentage of controlling interest or ownership	
TIN Number	Provider Number (if applicable)		

DISTRIBUTION: Submit completed form to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Road
Madison WI 53784-0006
Telephone: (800) 947-9627

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT

(For Mental Health/Substance Abuse Services)

The State of Wisconsin, Department of Health and Family Services, hereinafter referred to as the Department, hereby enters into an agreement with (fill in name here)

Provider's Name – Name must exactly match the name used on all other documents.

a Provider of Healthcare services, hereinafter referred to as the Provider, to provide services under Wisconsin's Medicaid program, subject to the following terms and conditions:

1. The Provider shall comply with all federal laws, including laws relating to Title XIX of the Social Security Act, State laws pertinent to Wisconsin's Medicaid program, official written policy as transmitted to the Provider in the Wisconsin Medicaid Program Handbooks and all other publications, the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the Department of Health and Family Services Standards for Equal Opportunity in Service Delivery, section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and the Wisconsin Fair Employment Law, as are now in effect or as may later be amended.

2. The Department shall reimburse the Provider for services and items properly provided under the program in accordance with the "Terms of Reimbursement," as are now in effect or as may later be amended.

3. The Provider shall ensure that the services are equally available to all eligible Medicaid recipients subject to the availability of resources.

4. The Provider shall be liable for the entire amount of any overpayment, as defined by Medicaid program policies and procedures.

5. The Provider shall also be liable for the entire amount of an audit adjustment and/or disallowance attributed to the Provider by the Federal Government or by the Department. No fiscal sanction shall, under this paragraph, be taken against a Provider unless it is based upon a specific policy which was: (a) effective during the time period that is being audited; and (b) communicated to the Provider in writing by the Department or the Federal Government prior to the time period audited.

6. The Provider shall assure and document the availability and use of non-federal funds sufficient to provide for the non-federal share of all Wisconsin Medicaid program payments under this agreement.

7. In accordance with 42 CFR s. 431.107 of the federal Medicaid regulations, the Provider agrees to keep any records necessary to disclose the extent of services provided to recipients, upon request, and to furnish to the Department, the Secretary of the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid program.

8. The Provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. The Provider shall furnish to the Department in writing:

   (a) the names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

   (b) the names and addresses of all persons who have a controlling interest in the Provider;

   (c) whether any of the persons named in compliance with (a) and (b) above are related to another as spouse, parent, child, or sibling;

   (d) the names, addresses, and any significant business transactions between the Provider and any subcontractor; and

   (e) the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare or Medicaid since the inception of those programs.

9. The Provider hereby affirms that it and each person employed by it for the purpose of providing services holds all licenses or similar entitlements as specified in HFS 101 to 108 and required by federal or state statute, regulation, or rule for the provision of the service.

10. The Provider consents to the use of statistical sampling and extrapolation as the means to determine the amounts owed by the Provider to the Medicaid program as a result of an investigation or audit conducted by the Department, the Department of Justice Medicaid Fraud Control Unit, the federal Department of Health and Human Services, the Federal Bureau of Investigation, or an authorized agent of any of these.

11. Unless earlier terminated as provided in paragraph 12 below, this agreement shall remain in full force and effect for a maximum of one year, with the agreement expiring annually on March 31. Renewal shall be governed by s. HFS 105.02(8), Wisconsin Administrative Code.

12. This agreement may be terminated as follows:

    (a) By the Provider as provided at s. HFS 106.05, Wisconsin Administrative Code.

    (b) By the Department upon grounds set forth at s. HFS 106.06, Wisconsin Administrative Code.

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid program administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for those services

NOTE: This note applies for these services: crisis intervention services, community support program services, comprehensive community services, mental health and/or substance abuse outpatient services in the home or community. Both the biller (matching funds agency) and the non-biller (performer) must apply for certification separately to obtain separate provider numbers, which are required for submitting claims.

ALL THREE PAGES OF THIS PROVIDER AGREEMENT MUST BE RETURNED TOGETHER

_____
Name of Provider (Typed or Printed)

_____
Physical Street Address

_____
City State Zip

TITLE:_____

BY:_____
Signature of Provider

DATE:_____

(For Department Use Only)

STATE OF WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES

BY:_____

DATE:_____

MODIFICATIONS TO THIS AGREEMENT CANNOT AND WILL NOT BE AGREED TO. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.

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_____
Name of Provider (Typed or Printed)

_____
Physical Street Address

_____
City State Zip

TITLE:_____

BY:_____
Signature of Provider

DATE:_____

(For Department Use Only)

STATE OF WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES

BY:_____

DATE:_____

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WISCONSIN MEDICAID
ELECTRONIC BILLING GENERAL INFORMATION

Wisconsin Medicaid has several electronic billing options available for trading partners to submit electronic claims. HIPAA compliant Software is available at no cost for submitting claims to Wisconsin Medicaid except for retail pharmacy services. For further information, or to order free software refer to: http://www.dhfs.state.wi.us/medicaid9/pes/pes.htm or contact the Provider Services at 1-800-947-9627 or the EDI Department at 608-221-9036.

ELECTRONIC METHODS FOR SUBMITTING MEDICAID CLAIMS

- Provider Electronic Solutions (PES) – Wisconsin Medicaid HIPAA Compliant Free Software
    - 837 Institutional
    - 837 Professional
    - 837 Dental
    - 997 Functional Acknowledgement
    - 835 Health Care Payment Advice

- Cartridge - Providers with the capability to create their claim information on 3480, 3490 or 3490E cartridge can submit those tapes to Wisconsin Medicaid in the HIPAA compliant formats.

- RAS/Internet – Allows providers to send their data files to Wisconsin Medicaid using a direct RAS connection or Web Browser.

- Third Party Biller – Providers have the option of purchasing a billing system or contracting with a Third Party Biller, to submit their claims.